REFERRAL FOR SERVICE

NAME OF INDIVIDUAL BEING REFERRED: ____

ADDRESS (Including Postal Code) ____

____

Phone #:____________________________

Date of Birth (MM/DD/YR) ______________________ Gender: ☐ Male ☐ Female

Preferred Language: English__________ French_________ Other (please specify)____________

Interpreter Services Required? ☐ Yes ☐ No

CONTACT INFORMATION

Name of Person/Agency Making the Referral (relationship to person being referred):

Name: ______________________________ Relationship: ____________________________

Address (Including Postal Code):____

Phone #: ____________________________ Email: ______________________________

Primary Contact: ________________________ Phone#: ______________________________

Next of Kin: ____________________________ Relationship to Person Being Referred: __________

Address (Including Postal Code): ____

____

Home Phone #: ______________ Business Phone #: _____________ Email: _________________

Emergency Contact (if not the same as next of kin): ______________________________

Address ____Phone # : ________________

Is There a Substitute Decision Maker? ☐ Yes ☐ No If yes, do they consent for: ☐ Financial ☐ Personal Care

Name & Relationship: ____

Has there been a capacity assessment completed? ☐ Yes ☐ No

REFERRAL FOR SERVICE

REASON FOR REFERRAL

Please provide a brief description of the reason(s) for a referral to Regional Support Associates (*Please be as specific as possible*)

____

____

____

____

Previous Involvement with RSA ☐ Yes ☐ No

Presenting Issues

Risk of Losing Housing/Day Program ☐ Yes ☐ No Comment: ________________________________

Risk of Losing Financial Support ☐ Yes ☐ No Comment: ________________________________

Risk of Self Harm ☐ Yes ☐ No Comment: ________________________________

Risk of Harm to Others ☐ Yes ☐ No Comment: ________________________________

Physical/Sexual Abuse ☐ Yes ☐ No Comment: ________________________________

Substance Abuse/Addictions ☐ Yes ☐ No Comment: ________________________________

Risk of Hospitalization ☐ Yes ☐ No Comment: ________________________________

Risk of Suicide ☐ Yes ☐ No Comment: ________________________________

Other (please specify): ____

How long have the above concerns been present? ____

What is currently being done to manage or cope with the issues? ______________________________

____

What assistance would you like from Regional Support Associates? _____________________________

____

____

REFERRAL FOR SERVICE

LIVING SITUATION

CURRENT

☐ Alone ☐ Family ☐ 24 Hour Supported ☐ With Others ☐ Other (Specify) _______________

____

☐ Group Home ☐ Independent Living ☐ Rest Home ☐ Long Term Care Facility

☐ Other (specify) ____

____

PAST

1. ____
2. ____
3. ____

INDIVIDUAL HISTORY

ASSSESSMENT INFORMATION

Nature of Developmental Disability (ie. Down's syndrome, Fragile X): ____

____

Diagnosed by Whom? ______________________________________ Year: ________________________________

Psychiatric Diagnoses (if known) ________________________________ Diagnosed by Whom: _____________________

Previous Psychological Assessment? ☐ Yes ☐ No

If Yes, by Whom: ____ Year: ______________________

Contact Information (Address & Phone#):

____

Was Testing Done at School or Privately? ☐ School ☐ Privately ☐ Other (specify)

REFERRAL FOR SERVICE

EDUCATION

Has the individual received special education? ☐ Yes ☐ No

If yes, please describe the special education program(s) or services and the Board of Education the individual attended.

____

Did the individual attend high school? If so, please note the name of the school attended. ______________________________

Is an IPRC/IEP document available? ☐ Yes ☐ No

MEDICAL

Name of Family Physician ___________________________________ Contact Information: ________________________

Has person being referred had a complete physical examination and medical review in the last 12 Months? ☐ Yes ☐ No
If not, date of last known complete physical examination and medical review. ____

Medical Diagnosis/Concerns (Diabetes, etc.)
____

____

Has Genetic Testing Been Done? ☐ Yes ☐ No ☐ Unknown

Is the person presently seeing any specialist? ☐ Yes ☐ No Has the person seen any specialists in the past? ☐ Yes ☐ No

If yes, please specify type of specialists, reason for seeing a specialist and contact information.

1. ____
2. ____
3. ____

CURRENT MEDICATIONS

NAME	DOSAGE	REASON

REFERRAL FOR SERVICE

ADAPTIVE LIVING SKILLS

Is this person able to do each of these activities independently?

Mobility (walk, walker, wheelchair, etc.)	☐ Yes	☐ With Help	☐ No
Eating	☐ Yes	☐ With Help	☐ No
Cooking	☐ Yes	☐ With Help	☐ No
Selecting Clothes to Wear	☐ Yes	☐ With Help	☐ No
Getting Dressed	☐ Yes	☐ With Help	☐ No
Toileting	☐ Yes	☐ With Help	☐ No
Personal Care	☐ Yes	☐ With Help	☐ No
Going to Community Activities	☐ Yes	☐ With Help	☐ No

COMMUNICATION SKILLS

Please indicate the person's method(s) of communication (*Please indicate primary and secondary method of communication*)

Expressive: ☐ Pointing/Reaching ☐ Gestures/Facial Expressions ☐ 2-3 Word Combinations

☐ Single Words/Signs/Symbols ☐ Sentences ☐ American Sign Language ☐ Other (describe) _______________

Receptive: ☐ Conversational speech/sign ☐ Single word/sign ☐ simple verbal directions ☐ physical prompts or environmental cues

Have there been any changes to the method of communication? ☐ Yes ☐ No

What does the person do when he/she is not understood?
____

____

REFERRAL FOR SERVICE

Please provide a list of all agencies currently involved with this person. (no contact will be made without informed written consent)

AGENCY & CONTACT INFORMATION	TYPE OF SERVICE PROVIDED (and frequency of contact)

Has the Person experienced trauma in their life? ☐ Yes ☐ No If yes, what type of trauma and at what age ?

____

Is there a reason for a preferred consultant, male or female? ☐ Yes ☐ No If yes, please explain why.

____

IS THERE ANYTHING ELSE YOU THINK WE SHOULD KNOW BEFORE WE BEGIN THE CONSULTATION PROCESS?

____

____

____

Date Completed: ___________________________

PLEASE COMPLETE THE ATTACHED REQUIRED CONSENTS

Please forward the completed referral package to Jayne Joyes, Senior Administrative Assistant,

By Fax (519) 421-4249 or By Mail to

Regional Support Associates
293 Wellington St. N.
Woodstock, Ontario
N4S 6S4

Thank you for taking the time to complete this form. If Depending on the nature of the referral, further information may be requested.

REFERRAL FOR SERVICE

INFORMED CONSENT TO REFERRAL AND PRELIMINARY ASSESSMENT

I,____,
Name

of ____
Address *City*

hereby authorize: ____________________________________ to make a referral to:

Name of Person or Agency

REGIONAL SUPPORT ASSOCIATES for:

MYSELF or __________________________________ D.O.B: ________________

Individual's Name

For the following Assessment and/or Treatment Services:

____
____
____
____

____________________________ ____________________________

Signature of Person Referred *Date:*

____________________________ ____________________________

Signature of Legal Guardian or Substitute Decision Maker *Relationship to Person Referred*

____________________________ ____________________________

Signature of Witness *Date*

Please Note: Where the Person is not of the legal age or lacks legal capacity to give consent, this Consent is to be signed by a Substitute Decision Maker and/or Legal Guardian *prior* to referral to treatment. When consent is signed by the Substitute Decision Maker and/or Legal Guardian, the relationship to the Person referred must be stated. Furthermore, when the Consent is given by the Substitute Decision Maker and/or Legal Guardian, it is most desirable to obtain the Consent and signature of the Person referred as well, provided *he or she has been fully informed* as much as possible. The Person referred by the Substitute Decision Maker has the right to refuse treatment and/or withdraw Consent even after this Consent is signed. This Consent is good only for the provision of the above-described referral.